APPENDIX

Appendix A – Integrated Treatment Consensus Panel Participants

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Appendix B – Consensus Panel Operating Rules

- The panel decided that the goal for *consensus* should be to try to achieve 100% agreement, but that a specific percentage was not as important as adopting a policy that all members "can live with it" within the context of a Win-Win. In achieving consensus everyone should be heard and the group must adopt something that can work. The panel should model what they expect to happen in the community and as part of consensus everyone in the group accept the final product. The final product does not have to be one model versus another model, but may include elements of more than one model and thereby easing the consensus process. Consensus at various levels and tolerance of various elements will be a key factor.

- The panel decided that *issue resolution* should include: written pros and cons of an issue, subject matter expertise (consultants), further research of an issue, and possible mediation.

- The panel did not see the need for a *chairperson* at this time, but left it open to decide at a later date should it be necessary to do so.

- The panel agreed on the *rules for the discussion* process: raising hands, round table; open communication/discussion; different opinions on the table - value the diversity of those opinions; treat others with respect; do not focus on history - focus on now and the opportunity before us; listen attentively; ask for clarification when necessary; and no hidden agendas.

- The panel decided that only non-voting *substitutes* be permitted, however there should be an opportunity to vote by proxy. Options for insuring all members have the opportunity to vote include: hold off on decisions until representation is present, use a quorum policy for voting, and/or use video conferencing or tele-conferencing. Another alternative is that the discussion process ends and the vote takes place at the beginning of the next meeting to give everyone an opportunity to vote or send a proxy vote. These options should be left open and as voting situations occur, the best option for the situation can be utilized.

- The panel decided that the process for *replacements* should include the following steps: the person leaving the panel may recommend a replacement to DBHS from their own agency or constituency; DBHS will recommend a replacement to the panel based on the input from the departing member; and the panel will approve or deny the recommended replacement. The replacement member should represent the same constituency.

Appendix C – Index of Periodicals

Name of Report	Author	Date
A Decade of MISA Initiatives in the State of Illinois, The 1990 Illinois Task Force Report for the Mentally Ill Substance Abuser	Joseph Mehr, Ph. D. (The Illinois MISA Newsletter)	June 1999
A New System Framework for Approaching the Problem of Co-Occurring Disorders, Designing a Comprehensive System of Care presentation	NASADAD 1999 Annual Meeting	June 9, 1999
Anxiety and Substance Abuse	Peter J. Pociluyko (Substance Abuse Letter)	1999
Arbour Health System Required Basic Competencies in Addiction/Dual Diagnosis for Adult Clinicians	Approved by Dual Diagnosis Committee	July 28, 1998
Arbour Health System Required Basic Competencies in Addiction/Dual Diagnosis for Child/Adolescent Clinicians	Approved by Dual Diagnosis Committee	September 29, 1998
Arizona Children Face Tough Transition Between Programs	Mental Health Weekly Newsletter	June 21, 1999
Assertive Community Treatment for Patients with Co-occurring Severe Mental Illness and Substance Use Disorder: A Clinical Trial	Robert E. Drake, M.D., Ph.D.; Gregory J. McHugo, Ph.D.; Robin E. Clark, Ph.D.; Gregory B. Teague, Ph.D., Haiyi Xie, Ph.D., Keith Miles, M.P.A., Theimann H. Ackerson, M.S.W.	1998
Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse	Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services	1995
(The) Better Living Skills Group	Kim T. Mueser, Ph.D, Melinda Fox, M.A., C.A.D.A.C., Linda B. Kenison, C.C.S.W., and Brad L. Geltz, M.A. A.T.R.	1995
Breaking Barriers to the Integration of Substance Abuse and Mental Health Services notice and notes		February 10, 1999
Brief History, Current Status and Future Place of Assertive Community Treatment	Robert E. Drake, MD, Ph.D. (American Journal of Orthopsychiatry)	April 1998

Name of Report	Author	Date
Case Management for People with Coexisting Severe Mental Disorder and Substance Use Disorder	Robert E. Blake, MD, Ph.D.; Douglas L. Noordsy, MD (Psychiatric Annals)	August 1994
Changing the Conversation: A National Plan to Improve Substance Abuse Treatment	Center for Substance Abuse Treatment	1999
Clinician Rating Scales: Alcohol Use Scale (AUS), Drug Use Scale (DUS), and Substance Abuse Treatment Scale (SATS)	Robert P. Drake, Kim T. Mueser, Gregory J. McHugo	
Community Action Grants Information		1998
Community Consensus-Building Collaborative Principles for the Care and Treatment of Dually Diagnosed Individuals		February 27, 1998
Community Support Program Demonstrations of Services for Young Adults with Severe Mental Illness and Substance Use Disorders, 1987-1991	Carolyn Mercer-McFadden, Robert E. Drake, Neal B. Brown, Risa S. Fox (Psychiatric Rehabilitation Journal)	Winter 1997
Consortium Membership, Consortium Summary, Glossary of Terms/Acronyms	MISA Consortium Final Subcommittee Reports	
Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula. Report of The Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project	Co-Occurring Mental and Substance Disorders Panel Kenneth Minkoff, MD, Panel Chair	January 1998
Coping with Schizophrenia a Guide for Families	Kim T. Mueser, Ph.D., Susan Gingerich, M.S.W.	
Cost-Effectiveness of Assertive Community Treatment Versus Standard Case Management for Persons with Co-Occurring Severe Mental Illness and Substance Use Disorders	Robin E. Clark, Gregory B. Teague, Susan K. Ricketts, Philip W. Bush, Haiyi Xie, Thomas G. McGuire, Robert E. Drake, Gregory J. McHugo, Adam M. Keller, Michael Zubkoff (HSR: Health Services Research)	December 1998
Cost-Effectiveness of Substance Disorder Interventions for the Severely Mentally Ill	Jeanette M. Jerrell, Ph.D.; Teh-wei Hu, Ph.D.; Susan Ridgely, M.S.W.	

Name of Report	Author	Date
Course, Treatment, and Outcome of Substance Disorder in Persons with Severe Mental Illness	Robert E. Drake, Ph.D.; Kim T. Mueser, Ph.D., Robin E. Clark, Ph.D., Michael A. Wallach, Ph.D. (American Journal of Orthopsychiatric Association)	January 1996
Dartmouth Assessment of Lifestyle Instrument (DALI): A Substance Use Disorder Screen for People With Severe Mental Illness	Stanley D. Rosenberg, Ph.D., Robert E. Drake, Ph.D., George L. Wolford Ph.D., Kim T. Mueser, Ph.D., Thomas E. Oxman, M.D., Robert M. Vidaver, M.D., Karen L. Carrieri, R.N., M.A., and Ravindra Luckoor, M.D.	February 1998
Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment	Center for Substance Abuse Treatment, U.S. Department of Health and Human Services	1995
DMH Proposal - Developing an Implementation Plan for Exemplary Practice: The Comprehensive Continuous Integrated System of Care for the Dually Diagnosed: A consensus Building Model	Submitted to Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS)	April 1997
Dual Diagnosis	Kenneth Minkoff, MD	
Dual Diagnosis: A Review of Etiological Theories	Kim T. Mueser, New Hampshire-Dartmouth Psychiatric Research Center; Robert E. Drake, New Hampshire-Dartmouth Psychiatric Research Center; Michael A. Wallach, Duke University (Addictive Behaviors)	1998
Dual Diagnosis: How Families Can Help	Kim T. Mueser, Ph.D. and Lindy Fox, M.A. CADAC	1998
Dual Diagnosis: Publications from the New Hampshire - Dartmouth Psychiatric Research Center, 1989 - present	New Hampshire – Dartmouth Psychiatric Research Center	January 1999
Dual Diagnosis: The New Hampshire Program	Robert E. Blake, MD, Ph.D.; Gregory B. Teague, Ph.D.; S. Reid Warren, III, MSW (Addiction & Recovery)	June 1990
Dually Diagnosed Substance Abusers: Diagnosis and Management	Igor Koutsenok, MD Pablo Stewart, MD	September 27-29, 1999
Empowerment Education: Friere's Ideas Adopted to Health Education	Nina Wallerstein, MPH, DrPH Edward Berstein, MD	1988

Name of Report	Author	Date
Epidemiology of Substance Use Disorders Among Persons with Chronic Mental Illnesses	Kim T. Mueser, Melanie Bennett, Matthew G. Kushner (Double Jeopardy: Chronic Mental Illness and Substance Use Disorders)	1995
(The) Exemplary Practice: *Assertive Community Treatment*		
Financing Assertive Community Treatment	Robin E. Clark (Administration and Policy in Mental Health)	November 1997
Group Treatment for Dually Diagnosed Clients	Kim T. Mueser, Douglas L. Noordsy (New Directions for Mental Health Services)	1996
Handbook of Social Functioning in Schizophrenia	Kim T. Mueser, Nicholas Tarrier	1998
Increasingly, The Mentally Ill Have Nowhere To Go. That's Their Problem And Ours.	Michael Winerip, New York Times	May 24, 1999
Initial Screening Protocol for Adolescents, Draft		November 23, 1998
Integrated Mental Health and Substance Abuse Treatment for Severe Psychiatric Disorders	Kim T. Mueser, Ph.D.; Robert E. Drake, M.D., Ph.D.; Douglas L. Noordsy, M.D. (Journal Prac. Psych. And Behav. Hlth.)	May 1998
Integrated Treatment for Dually Diagnosed Homeless Adults	Robert E. Drake, MD, Ph.D.; Nancy A. Yovetich, MA; Richard R. Rebout, Ph.D.; Maxine Harris, Ph.D.; Gregory J. McHugo, Ph.D. (The Journal of Nervous and Mental Disease)	1997
Intervention Strategies for Offenders with Co-Occurring Disorders: What Works?	Roger H. Peters, Ph.D., Holly A. Hills, Ph.D., Louis de la Parte Florida Mental Health Institute, University of South Florida	December 1997
Learner Developed Materials: An Empowering Product	Rima E. Rudd, ScD John P. Comings, EdD	1994
Mental Illness and Substance Abuse: Treatment Issues and Interventions	Kim T. Mueser, Ph.D.	
Methodological Issues in Assertive Community Treatment Studies	Gregory J. McHugo, Ph.D.; William Hargreaves, Ph.D.; Robert E. Drake, MD, Ph.D.; Robin E. Clark, Ph.D.; Haiyi Xie, Ph.D.; Gary R. Bond, Ph.D.; Barbara J. Burns, Ph.D. (American Orthopsychiatric Association)	1998

Name of Report	Author	Date
MISA Subcommittee Report: Service Guidelines and Protocols	MISA Consortium Final Subcommittee Reports	November 1998
MISA Subcommittee Report: Staff Credentials and Training	MISA Consortium Final Subcommittee Reports	
MISA Subcommittee Report: Adolescents	MISA Consortium Final Subcommittee Reports	
Missing Out on Motherhood	Lindy Fox, M.A., L.A.D.C.	February 1999
Models of Community Care for Severe Mental Illness: A Review of Research on Case Management	Kim T. Mueser, Gary R. Bond, Robert E. Drake, Sandra G. Resnick (Schizophrenia Bulletin)	1998
National Association of Mental Health Program Director Memorandum Re: Co-Occurring Mental Health and Substance Abuse Disorders	Jenifer Urff, JD, Director of Government Relations; Bruce D. Emery, MSW, Director of Technical Assistance	February 1, 1999
National Dialogue on Co-Occurring Mental Health and Substance Abuse Disorders	National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD)	March 1999
New Document of Co-Occurring Disorders Being Readied		
Overview of Assessment of Substance Abuse in Severely Mentally Ill Patients		
Overview Arizona TOPPS II	TOPPS II Arizona Consensus Panel	1999
Overview of Treatment Modalities for Dual Diagnosis Patients, Pharmacotherapy, Psychotherapy, and 12-Step Programs	Roger D. Weiss and Lisa M. Najavits, McLean Hospital Belmont and Harvard Medical School	1998
Preliminary Results Treatment Outcomes Pilot Prospective Study Arizona TOPPS I	Bureau of Substance Abuse and General Mental Health Division of Behavioral Health Services, Arizona Department of Health Services	June 1999
Program Components of a Comprehensive Integrated Care System for Serious Mentally Ill Patients with Substance Disorders	Kenneth Minkoff, MD	1991
Proposed Levels of MISA Practice		
Proving Treatment Works: State Challenges in Measuring Patient Out comes and System Performance	Christina Dye, Bureau of Substance Abuse and General Mental Health Services, Arizona Department of Health Services	

Name of Report	Author	Date
Readings in Dual Diagnosis order form	Edited by Robert Drake, Carolyn Mercer-McFadden, Gregory McHugo, Kim Mueser, Stanley Rosenberg, Robin Clark, and Mary Brunette	
Recommendations for a System of Care for Persons with Co-Occurring Mental Illness and Substance Use Disorders (MISA)	Pennsylvania Department of Health and Pennsylvania Department of Public welfare	May 1999
Review of Integrated Mental Health and Substance Abuse Treatment for Patients with Dual Disorders	Robert E. Drake, Carolyn Mercer-McFadden, Kim T. Mueser, Gregory J. McHugo, and Gary R. Bond (Schizophrenia Bulletin)	1998
(The) Role of Self-Help Programs in the Rehabilitation of Persons with Severe Mental Illness and Substance Use Disorders	Douglas L. Noordsy, M.D.; Brenda Schwab, Ph.D.; Lindy Fox, M.A.; Robert E. Drake, M.D., Ph.D. (Community Mental Health Journal)	1996
SAMSHA Position on treatment for Individuals with Co-Occurring Addictive and Mental Disorders		June 11, 1999
SAMHSA Subcommittee on Co-occurring Addictive and Mental Disorders Resolution		January 26, 1999
(A) Scale for Assessing the Stage of Substance Abuse Treatment in Persons with Severe Mental Illness	Gregory J. McHugo, Ph.D., Robert E. Drake, M.D. Heather L. Burton, M.A., and Theimann H. Ackerson, M.S.W.	1995
Scoring Instructions: The DALI Alcohol and Drug Scales		
Screening and Assessment of Co-Occurring Disorders in the Justice System	Roger H. Peters, Ph.D., Marla Green Bartoi, MA, Department of Mental Health Law and Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida	April 1997
(The) Technology of Consensus For System Change Presentation		
Treatment Manuals for Practitioners order form	A Guilford Series edited by David H. Barlow, Ph.D.	1997
Treatment of Drug-Dependent Individuals with Comorbid Mental Disorders	National Institute on Drug Abuse Research Monograph Series	1997

Name of Report	Author	Date
Treatment of Substance Abuse in Severely Mentally Ill Patients	Robert E. Drake, Ph.D.; Stephen J. Bartels, MD; Gregory B. Teague, Ph.D.; Douglas L. Noordsy, MD; Robin E. Clark, Ph.D. (The Journal of Nervous and Mental Disease)	1993
ValueOptions and ADHS/DBHS Strategic Plan for Dual Diagnosis		March 1, 1999
What is Motivation?	W.R. Miller	

Appendix D – Policy Recommendations

- Covered Services Policy
- Guidelines: Substance Dependence/Abuse

This appendix includes recommendations from the Arizona Integrated Treatment Consensus Panel to the Department of Health Services regarding the ADHS policy for Covered Services and the Guidelines: Substance Dependence/Abuse. It is recognized that the ADHS must take these policy recommendations through the required Policy Review process within the ADHS.

Arizona Department of Health Services
Division of Behavioral Health Services
Policy and Procedures Manual

Effective Date: XXXXX
Last Revision Date: 1/12/99

CHAPTER 1 PROGRAM SERVICES
POLICY X.2 COVERED SERVICES

1. PURPOSE: To define the behavioral health services covered by the Regional Behavioral Health Authorities

2. SCOPE: RBHAs and their subcontracted providers

3. POLICY: The RBHAs are responsible for maintaining a continuum of covered services for their contracted Geographic Service Area. A comprehensive listing of service codes, including funding source and other limitations and allowed provider types, is found in the ADHS/DBHS Service Matrix. **For persons who have more than one disorder**, these services shall be delivered in an integrated manner and in combinations commensurate with individual consumer needs.

4. REFERENCES:

5. PROCEDURES:

5.1 The RBHA is responsible for maintaining a continuum of covered services which may be provided for both mental health and substance abuse disorders:

1.1 **Alternative Residential Facilities -** Residential facilities other than inpatient and JCAHO Level 1 Residential Treatment Center in which covered services may be provided. Includes therapeutic group home, therapeutic foster care home, psychiatric health facility, crisis stabilization unit, supervised independent living facility, and any other licensed behavioral heath facility.

1.2 **Assessment/Evaluation -** Behavioral health assessments to determine and diagnose behavioral health problems, including substance abuse and dependence. This includes diagnosis and recommendations for intervention and/or treatment.

1.3 **Behavior Management** - Personal care, therapeutic supervision and direction; may include observation to prevent a person from harming self or others, assistance with activities of daily living and other household services incidental to, and consistent with, the behavioral health needs of the person.

1.4 **Case Management Services -** A supportive service provided to enhance treatment compliance and effectiveness. Activities include assistance in accessing, maintaining, monitoring and modifying covered services; assistance in finding necessary resources other than covered services to meet basic needs; communication and coordination of care; engagement, and follow-up of crisis contacts or missed appointments.

1.5 **Crisis Services -** An array of services provided to prevent, stabilize or resolve an acute or episodic change or anticipated change in a behavioral health condition that may result in the person's decompensation, relapse, hospitalization, or risk of harm to self or others.

1.6 **Consumer-Run Services -** Supportive behavioral health services staffed by consumers that may provide socialization, recreation and advocacy.

1.7 **Detoxification -** Treatment services provided to manage the acute signs and symptoms of withdrawal from substances of abuse by use of therapeutic procedures, medications, rest, diet, counseling, and/or medical supervision. May be provided in a variety of inpatient, residential and ambulatory settings.

1.8 **DUI Education -** Services provided to educate DUI offenders.

1.9 **DUI Screening -** Services provided to screen DUI offenders for the presence of alcohol or drug abuse and related problems using standardized tools and criteria.

1.10 **Education Services -**Services provided to consumers, families, or significant others.

1.11 **Family Therapy & Counseling -** Face to face therapeutic interaction with family members or significant others, with or without the presence of the enrolled person, to address the enrolled person's treatment goals. May be provided to multiple families.

Group Therapy and Counseling - Face to face therapeutic interaction to address the enrolled person's treatment goals with a group of enrolled persons.

1.12 **Individual Therapy and Counseling -** Face to face therapeutic interaction to address the enrolled person's treatment goals.

1.13 **In Home and Community Services -** Therapeutic activities provided to persons and/or their families in the home, school, pre-school, after school, nursery/day-care or other residential or non-office setting.

1.14 **Inpatient Hospital/Inpatient Acute Care -** Acute psychiatric treatment and/or detoxification provided in an inpatient acute care facility or licensed Level I Psychiatric Health Facility. There is no limitation of this service based on a sole diagnosis of substance abuse disorder.

1.15 **Inpatient Psychiatric Facility for Persons Under 21 Years of Age/Residential Treatment Center -** Active treatment provided under professional supervision in a JCAHO accredited Level I facility. There is no limitation of this service based on a sole diagnosis of substance abuse disorder.

1.16 **Laboratory, Radiology and Medical Imaging -** Laboratory, radiological and imaging services ordered for diagnosis, screening or monitoring of a behavioral health condition.

1.17 **Partial Care, Basic -** A regularly scheduled program of therapeutic services, provided in a group, including psychosocial rehabilitation, supportive counseling and other activities to promote coping, problem-solving, independent living and socialization skills or to prevent placement in a more restrictive setting.

1.18 **Partial Care, Intensive -** A regularly scheduled program of active treatment modalities, including individual, group and/or family therapy, psychiatric services and other therapeutic activities, provided in a group under the direction of a psychiatrist or psychologist, to address acute or episodic behavioral health problems or to prevent placement in a more restrictive setting.

1.19 **Pre-petition Screening, Court Ordered Evaluation and Treatment -** Screening, evaluation and treatment associated with involuntary commitment pursuant to A.R.S. Title 35, Chapter 5 Articles 1 through 9, consistent with the provisions of A.R.S. Title 36, Chapter 5, Article 6.

2.1 **Prescription Medications and Pharmacy -** Medications prescribed by a licensed physician, certified nurse practitioner in collaboration with a physician, or physician assistant under the direction of a physician and dispensed under the direction of a licensed pharmacist. The RBHA may not require prior authorization for medications on the ADHS/DBHS Statewide Formulary unless such prior authorization is based on and consistent with service planning guidelines or practice guidelines and is

approved by the ADHS/DBHS. The RBHA may require prior authorization for medications that are not on the ADHS/DBHS Formulary.

2.2 **Prevention Services -** Strategic interventions to reduce risk, increase resilience or promote the health of persons, families and communities who are at risk for the development or emergence of behavioral health disorders.

2.3 **Psychosocial Rehabilitation -** A program of remedial treatment to rehabilitate skill deficits. May include skill building in management of assaultive behavior, social integration and other activities of community and daily living.

2.4 **Psychiatric Nursing Services -** Nursing services by an RN who meets the qualification specified in R9-20-306(B) for a behavioral health professional.

2.5 **Psychiatric Services -** Psychiatric evaluation, management, consultation and other professional services provided by licensed allopathic or osteopathic physicians who are board-certified or who have completed an accredited residency in psychiatry.

2.6 **Psychological Services -** Evaluation, consultation, testing and other professional services provided by licensed psychologists.

2.7 **Residential Services -** Behavioral health services provided in an array of licensed out of home living environments to meet therapeutic goals for the person. Includes therapeutic group homes, crisis stabilization and detoxification facilities, therapeutic foster care and other facilities that provide a supportive, protective environment, improve or stabilize the person's behavioral health, systematically reduce dependence on alcohol and other drugs, or prevent placement in a more restrictive environment.

2.8 **Respite -** Planned, short-term therapeutic care, consistent with the behavioral health needs of the person, to supplement behavioral health care, to provide a safe living environment and/or to support family and other care givers for the benefit of the person. For Title XIX and XXI eligible persons, respite services may be coded using the behavior management service codes.

2.9 **Screening -** A brief face-to-face assessment of behavioral health status with preliminary recommendations for covered services including the need for further evaluation or determination that no behavioral health

need exists. Screening includes identification of and early intervention to persons who are at risk for the development or emergence of behavioral health disorders.

3.0 (Specialized) Integrated Substance Abuse Treatment - An array of structured interventions to reduce or eliminate abuse and dependence on alcohol and other drugs and to address other adverse conditions related to substance abuse. Interventions are provided in a range of outpatient, inpatient and residential settings and (can) shall include detoxification, methadone maintenance, recovery support services, and prevention and education services for the consumer and family, provided in a manner integrated with treatments of other mental/ behavioral health problems.

3.1 Supported Housing Services - Services provided to assist the person to obtain and maintain housing in an independent community setting. Does not include rent subsidy or other housing costs.

3.2 Transportation - Emergency and non-emergency transportation to medically necessary covered services. In an emergency, transportation is to the nearest appropriate emergency facility.

3.3 Vocational Services - Services to prepare the person for or maintain competitive employment. Activities include but are not limited to vocational screening, evaluation and training, and sheltered or supported employment.

F. APPROVED BY:

_____ _____

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SERVICE PLANNING GUIDELINES
SUBSTANCE DEPENDENCE AND/OR ABUSE

Published: April 28, 1997
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I. Target Group: Substance dependence and/or abuse, with or without other co-existing psychiatric disorders

Diagnosis:	304.xx, 305.xx, 303.xx, 291.xx, 292.0, 292.89
Severity:	Moderate to severe

II. Desired Outcome

A. Phase Relevant Goals

Phase 1 **Engagement**—Person:
- a. has regular contact with case manager or treatment staff.

Phase 2 **Persuasion**—Person:
- a. is engaged in a relationship with a case manager or counselor
- b. is discussing substance use or attending group, and
- c. shows evidence of reduction in use for at least 1 month.

Phase 3 **Active Treatment**—Person:
- a. is engaged in treatment
- b. has acknowledged that substance abuse is a problem
- c. is demonstrating abstinence or substantially reduced use that results in no impairment of functioning
- d. has reduced interest/involvement with substance involved peers and activities, and
- e. maintains behavior appropriate to developmental/cognitive level at home, work, and in the community.

Phase 4 **Relapse Prevention**—Person:
- a. has no substance related problems for over 1 year
- b. has awareness that relapse could happen
- c. can verbalize potential signs and symptoms of relapse or recurrence of their disorder(s)
- d. has identified and developed strategies for coping with exacerbating factors (including discontinuation of therapeutic activities and supports, loss, illness, depression, anxiety, and contact with former substance use situations and peers).

B. Observable stabilization or improvement in all identified co-occurring disorders/symptoms.

C. Physiologic Functioning:

Developmentally appropriate physiologic functioning (sleep, appetite, energy), for a period of time, to be determined based on the substance used.

Improvement in general health; medical problems related to substance use will be identified and referrals facilitated as needed.

D. Dangerousness to self or others:

Any thoughts or behaviors which may be dangerous to self or to others are brief, infrequent and not associated with behavioral intent. (See also Risk Assessment.)

E. Environmental Support

Behavioral health providers, medical providers, and other involved agencies will be collaborating effectively in appropriate interventions for the person.
The person's primary social supports (parents, care givers, spouse, significant others, employers, etc.) will demonstrate knowledge of and appropriate response to the person's:

Prominent psychiatric symptoms
Physiologic functioning
Exacerbating or relapse factors and relapse symptoms
Dangerousness to self or others

The person and family will be educated regarding the risk of association with substance-involved peers and activities.

The person will be engaged in and committed to regular attendance in a self-help/support group such as AA.

III. Major Differential Diagnoses and Comorbid Conditions

A. Substance abuse and dependence can present symptoms similar to a variety of primary psychiatric disorders, including anxiety disorders, mood disorders and psychotic disorders. Unless symptoms of a psychiatric disorder have been documented before the onset of substance abuse or during periods of documented abstinence, diagnosis of a concomitant disorder should be delayed until after at least 30 days of documented abstinence, to ensure that acute symptoms directly related to substance use have remitted. Treatment of the mental health and substance abuse symptoms will be provided regardless of abstinence status. Treatment will be provided based on the presence of symptoms regardless of substance use or mental health

issues. Provisional diagnosis and treatment should begin regardless of abstinence. The diagnosis and treatment plan should be reviewed at 30 days. Sleep disorder or cognitive disorder due to substance abuse may persist for up to 12 months.

Substance abuse is likely to be co-occurring with most SMI psychiatric disorders. ECA study estimates the lifetime occurrence of substance abuse in schizophrenia as 48% and in bipolar disorder as 56%. Occurrence within the past 6 months was 25-35%.[1] Substance abuse should be suspected as being comorbid with most psychiatric disorders, including:

Oppositional Defiant Disorder
Attention-Deficit/Hyperactivity Disorder
Personality Change due to a General Medical Condition
Mood Disorders
Anxiety Disorders
Posttraumatic Stress Disorder
Antisocial Personality Disorder
Borderline Personality Disorder
Conduct Disorder

These are to be considered as differential diagnoses upon or prior to the initial diagnosis, and upon relapse, exacerbation, and/or failure to improve after treatment/intervention of up to three months. Identified comorbidity should be addressed with the corresponding service planning guide.

B. Medication Treatment for Co-occurring Disorders

1. If acute psychotic symptoms, severe depression or anxiety is present, immediate psychiatric evaluation should be arranged. If psychotropic medications are prescribed, their use should be reevaluated at least every thirty days ~~after abstinence has been achieved,~~ for the first six months, and at least every 60 days for the next six months, with the express purpose of eliminating unnecessary medication.

2. Psychotic Disorders:

   It is imperative that persons with psychotic disorders or symptoms be treated ~~continuously~~ with the appropriate psychotropic medication, regardless of the current status of substance use, abuse or dependence. In general, the benefits outweigh the risks of treating [non substance-induced] psychotic disorders with psychotropic medications.

3. Affective Disorders and Anxiety Disorders:

   a. Persons with new onset of affective disorder or anxiety disorder symptoms while actively abusing alcohol or other drugs occasionally require brief intervention with psychotropic medication. Continuous use of such medication, however, should ordinarily not occur ~~receive psychotropic medication for those symptoms~~ unless the symptoms persist after 30 days of abstinence.

   b. If psychotropic medications are prescribed for a person with new onset of affective or anxiety, the person should be reevaluated at least monthly to determine need for the medication after a longer period of abstinence or reduced substance use.

4. Medications known to reduce cravings should be considered should be provided based on current best practice guidelines for integrated treatment services.

IV. Interventions

Type
Initial psychiatric evaluation
Subsequent psychiatric evaluation and management
Laboratory studies, (including urinalysis and toxicology screening), as needed
~~Inpatient or residential~~ Detoxification
Any combination of therapeutic, behavioral and educational interventions, including:

- Substance abuse family and group therapy (Groups should have both an educational component and a psychotherapeutic component).
- Community support groups (AA, NA, disorder-specific)
- Recreational/Occupational/Social Skills Therapies (See V. A. 3.)
- Intensive In Home Therapy
- Individual Therapy (less preferred modality)[1]

Other levels of care as clinically indicated (inpatient[2], residential[2], day treatment, etc.)

[1] Group therapy is the preferred modality, but may not be available because of lack of sufficient number of group members

[2] Both inpatient and residential treatment centers are covered Title XIX/XXI services for persons with substance use disorders who are otherwise entitled to these services.

V. Recommended Practice and Coordination

A. DBHS

1. Integrated Assessment, Treatment and Recovery – Psychiatric and substance disorders, regardless of severity, tend to be persistent and recurrent, and these disorders co-occur with sufficient frequency and complicate each other so that a continuous and integrated approach to assessment, treatment and recovery is required. Regardless of the location of initial and subsequent clinical presentations, integrated services should be available to anyone who would benefit. Assessments must be inclusive of both disorders and must include understanding the individual in the context of their home, community, etc.

2. Continuity of Care – The comprehensive integrated service system will provide early access to continuous integrated treatment relationships which can be maintained over tie, through multiple episodes of acute and sub-acute treatment and follow-up care. Maintaining these relationships is independent of any particular treatment setting.

3. Dual Primary Treatment – The recommended treatment approach is integrated dual primary treatment, in which:

   a. Each disorder receives specific and appropriately intensive integrated primary treatment that takes into account the level of severity and engagement for each disorder, and any complications resulting from the co-occurring disorders.
   b. Each individual has a primary treatment relationship with an individual who coordinates ongoing treatment interventions for all co-occurring disorders.
   c. Each individual receives treatment for co-occurring disorders in the setting or service system that is most appropriate to the needs of the individual.
   d. Each individual has access to clinicians on the Multidisciplinary Teams who have expertise in both mental health and substance abuse treatment as well as expertise in mental health / substance abuse co-occurring disorders. When the individual has a serious mental illness, the Team will include expertise specific to SMI treatment.

4. Empathic Relationship – The single most important factor for recovery from co-occurring illnesses is an empathic service relationship in which the individual experiences the hope of dual recovery and is considered to have the potential to achieve dual recovery.

5. Recovery Model – The recovery model as used herein, includes harm reduction and disease management models as well as recovery models. Disease management and recovery models are used for conceptualizing assessment and treatment for both disorders. For purposes of this

document, recovery is defined as a process by which an individual with a persistent, possibly disabling disorder, recovers self-esteem, self-worth, pride, and dignity and meaning through acquiring increasing ability to maintain stabilization of the disorders, by developing symptom management skills, and the capacity to maximize functioning within the constraints of the disorder.

6. Developmental Model – Persons with co-occurring disorders need a judicious combination of supportive case management and care to stabilize symptoms, and empathic detachment and empowerment to promote recovery and self-sufficiency.

7. Co Occurring Medication and Substance Use – It is imperative that persons with mental health and substance abuse co-occurring disorders are provided access to effective medications for both disorders. For example, the presence of substance use, abuse, or dependence does not preclude the provision of psychotropic medications.

8. Unconditional Commitment - There will be a long term, unconditional commitment to the individual. Expectations will be realistic and individuals will be provided a welcoming environment initially and at all times thereafter.

9. Cultural Competency – The system will provide culturally relevant care that addresses and respects language, customs, values and mores and will have the capacity to respond to the individual's unique family, culture, traditions, and strengths.

10. Effectiveness – The services will be outcome based as defined by the consumer and will provide evidence of effectiveness through the appropriate use of periodic outcome evaluations and consumer satisfaction assessments.

11. Past records and collateral information from family should be made available, including prior treatment outcomes, prior to the initial evaluation by a psychiatrist, if possible

12. Medical detoxification services should be used for persons who have <u>significant</u> physiological withdrawal, toxic symptoms, risk of seizures, or require other medical interventions.

13. Other than detoxification, the purpose of treatment in a restrictive setting should be to engage/connect the person to the appropriate community-based resources <u>and to break the pattern of use</u>, not to achieve lasting abstinence.

14. Treatment modalities, focus and strategies:

Treatment should focus on a cognitive/educational approach with the person and family. Social/recreational/vocational skills need to be developed to reduce exposure to substance-involved peers and increase engagement in other community activities as alternatives to substance use. This may include active assistance in identifying and joining community programs and activities.

Specific treatment programs include:

School/vocational education program; HIV/AIDS prevention and early intervention; Pregnancy/contraception--coordination of care for pregnant teens; Perinatal Substance Abuse program; Education of physicians and others about early identification and screening of substance abuse;

Behavioral strategies have been shown to be effective in the treatment of cocaine abuse. Examples include monetary or other rewards for concrete evidence of abstinent behavior, such as negative drug screens ("clean urines").

Other effective treatment strategies include:
Motivational interviewing, and relapse prevention strategies/programs, which may require changes in peer group, school, and other support and leisure systems to promote involvement in non drug-oriented activities;

Treatment planning should address (at a minimum) the individual's medical needs, identified psychiatric needs and rehabilitation, substance-specific treatment needs, family/social needs, academic/vocational needs, legal needs.

15. Development of targeted symptoms and goals:

In collaboration with the significant social supports, and other involved professionals, a list of targeted symptoms and treatment goals should be developed as outlined in Section II

16. Risk assessment:

The person should be evaluated initially and continually for presence and absence of common risk factors of dangerousness to self and to others. The person and, where indicated, significant social support should understand:

- the level of risk associated with the person's presentation and disorder
- specific steps to take in order to how to access crisis services the
- role of guns, drugs, alcohol and impulsivity in ongoing risk prevention
- minimize risk

B. Medical Health Services

1. All relevant psychiatric assessment and treatment plans, including medications, should be communicated to the PCP to ensure coordination of services.

2. Special attention should be given to coordination of perinatal care and substance abuse treatment.

3. HIV, tuberculosis and hepatic conditions often associated with alcohol and injection drug abuse; screening and shared management for these disorders may be necessary.

C. Collateral Resources

1. Division of Developmental Disabilities

   Referral to DDD should be made for eligibility determination if there is evidence of impairment indicating a need for DD services. If DDD is providing services related to the developmental disability, such services should be coordinated with the behavioral health services.

2. Juvenile or Adult Probation

   Condition of probation, parole and related services should be coordinated with the behavioral health services. The behavioral health service provider should understand the terms of court orders and conditions of probation and parole, if any. Information should be provided as necessary and services coordinated with court, probation and parole.

3. AHCCCS/ALTCS

   Referral to ALTCS should be made for eligibility determination if there is evidence of impairment indicating a need for ALTCS services. If ALTCS is providing services related to the developmental disability, such services should be coordinated with the behavioral health services.

4. Child Protective Services

   For children, report to CPS (DES/ACYF) must be made when there is suspicion of neglect or abuse, including medical or emotional. For open CPS cases the case plan should be coordinated with the behavioral health services.

5. Vocational Rehabilitation

   As required, referral should be made and services coordinated.

6. Education

The parent/legal guardian will be advised to request the school district's cooperation with the overall evaluation and treatment process. This will include the school's participation in the initial and ongoing evaluation and interventions. The parent may also request the school provide a comprehensive evaluation to determine special education eligibility or an accommodation assessment.

VI. Suggested Review Criteria

1. Reviews will be based on ASAM criteria for given levels of care.

2. After successful engagement, initial treatment should be based on the phase/stage of the disorder and on medical necessity, i.e., based on the anticipated frequency, intensity, and duration of services needed to achieve desired/expected outcomes.

3. Successful treatment may involve an extended, gradual effort. Progress should be reviewed at least monthly. If there is failure to improve after treatment/intervention of [up to] three months, the diagnosis (or diagnoses) and treatment should be reevaluated.

4. Subsequent periods of treatment should be authorized if active treatment is occurring, as evidenced by:

   a. the treatment plan has been implemented; and

   b. progress towards the desired outcomes has been made and/or there is a reasonable expectation that desired outcomes will be achieved with continued treatment; and/or

   c. the treatment plan has been modified if ineffective.

Appendix E – Glossary of Services

Alternative Residential Facilities - Residential facilities other than inpatient and JCAHO Level 1 Residential Treatment Center in which covered services may be provided. Includes therapeutic group home. therapeutic foster care home, psychiatric health facility. crisis stabilization unit, supervised independent living facility, and any other licensed behavioral heath facility.

Assessment/Evaluation-Behavioral health assessments to determine and diagnose behavioral health problems, including substance abuse and dependence. This includes diagnosis and recommendations for intervention and/or treatment.

Behavior Management - Personal care, therapeutic supervision and direction; may include observation to prevent a person from harming self or others, assistance with activities of daily living and other household services incidental to, and consistent with, the behavioral health needs of the person.

Case Management Services - A supportive service provided to enhance treatment compliance and effectiveness. Activities include assistance in accessing, maintaining, monitoring and modifying covered services; assistance in finding necessary resources other than covered services to meet basic needs, communication and coordination of care; engagement, and follow-up of crisis contacts or missed appointments.

Crisis Services - An array of services provided to prevent, stabilize or resolve an acute or episodic change or anticipated change in a behavioral health condition that may result in the person's decompensation. relapse, hospitalization, or risk of harm to self or others.

Consumer-Run Services - Supportive behavioral health services staffed by consumers that may provide socialization, recreation and advocacy.

Detoxification - Treatment services provided to manage the acute signs and symptoms of withdrawal from substances of abuse by use of therapeutic procedures, medications, rest, diet, counseling, and/or medical supervision. May be provided in a variety of inpatient, residential and ambulatory settings.

DUI Education - Services provided to educate DUI offenders.

DUI Screening - Services provided to screen DUI offenders for the presence of alcohol or drug abuse and related problems using standardized tools and criteria.

Family Therapy & Counseling - Face to face therapeutic -interaction with family members or significant others, with or without the presence of the enrolled person, to address the enrolled person's treatment goals. May be provided to multiple families.

Group Therapy and Counseling - Face to face therapeutic interaction to address the enrolled person's treatment goals with a group of enrolled persons.

Individual Therapy and Counseling - Face to face therapeutic interaction to address the enrolled person's treatment goals.

In Home and Community Services - Therapeutic activities provided to persons and/or their families in the home, school, pre-school, after school, nursery/day-care or other residential or non-office setting.

Inpatient Hospital/Inpatient Acute Care - Acute psychiatric treatment and/or detoxification provided in an inpatient acute care facility or licensed Level I Psychiatric Health Facility. There is no limitation of this service based on a sole diagnosis of substance abuse disorder.

Inpatient Psychiatric Facility for Persons Under 21 Years of Age/Residential Treatment Center Active treatment provided under professional supervision in a JCAHO accredited Level I facility. There is no limitation of this service based on a sole diagnosis of substance abuse disorder.

Laboratory, Radiology and Medical Imaging - Laboratory, radiological and imaging services ordered for diagnosis, screening or monitoring of a behavioral health condition.

Partial Care, Basic - A regularly scheduled program of therapeutic services, provided in a group, including psychosocial rehabilitation, supportive counseling and other activities to promote coping. problem-solving, independent living and socialization skills or to prevent placement in a more restrictive setting.

Partial Care, Intensive - A regularly scheduled program of active treatment modalities, including individual, group and/or family therapy, psychiatric services and other therapeutic activities, provided in a group under the direction of a psychiatrist or psychologist,., to address acute or episodic behavioral health problems or to prevent placement in a more restrictive setting.

Pre-petition Screening, Court Ordered Evaluation and Treatment Screening, evaluation and treatment associated with involuntary commitment pursuant to ARS Title 35, Chapter 5 Articles I through 9, consistent with the provisions of ARS Title 36, Chapter 5, Article 6.

Prescription Medications and Pharmacy - Medications prescribed by a licensed physician, certified nurse practitioner in collaboration with a physician, or physician assistant under the direction of a physician and dispensed under the direction of a licensed pharmacist. The RBHA may not require prior authorization for medications on the ADHS/DBHS Statewide

Prevention Services - Strategic interventions to reduce risk, increase resilience or promote the health of persons. families and communities who are at risk for the development or emergence of behavioral health disorders.

Psychosocial Rehabilitation - A program of remedial treatment to rehabilitate skill deficits. May include skill building in management of assaultive behavior, social integration and other activities of community and daily living.

Psychiatric Nursing Services - Nursing services by an RN who meets the qualification specified in R9-20-306(B) for a behavioral health professional.

Psychiatric Services - Psychiatric evaluation, management. consultation and other professional services provided by licensed allopathic or osteopathic physicians who are board-certified or who have completed an accredited residency in psychiatry.

Psychological Services - Evaluation, consultation, testing and other professional services provided by licensed psychologists.

Residential Services - Behavioral health services provided in an array of licensed out of home living environments to meet therapeutic goals for the person. Includes therapeutic group homes. crisis stabilization and detoxification facilities, therapeutic foster care and other facilities that provide a supportive, protective environment, improve or stabilize the person's behavioral health, systematically reduce dependence on alcohol and other drugs, or prevent placement in a more restrictive environment.

Respite - Planned, short-term therapeutic care, consistent with the behavioral health needs of the person. to supplement behavioral health care- to provide a safe living environment and/or to support family and other care givers for the benefit of the person. For Title XIX and XXI eligible persons. respite services may be coded using the behavior management service codes.

Screening - A brief face-to-face assessment of behavioral health status with preliminary recommendations for covered services including the need for further evaluation or determination that no behavioral health need exists. Screening includes identification of and early intervention to persons who are at risk for the development or emergence of behavioral health disorders.

(Specialized) Integrated Substance Abuse Treatment - An array of structured interventions to reduce or eliminate abuse and dependence on alcohol and other drugs and to address other adverse conditions related to substance abuse. Interventions are provided in a range of outpatient, inpatient and residential settings and (can) shall include detoxification, methadone maintenance, recovery support services. and prevention and education services for the consumer and family, provided in a manner integrated with treatments of other mental/ behavioral health problems.

Supported Housing Services - Services provided to assist the person to obtain and maintain housing in an independent community setting. Does not include rent subsidy or other housing costs.

Transportation - Emergency and non-emergency transportation to medically necessary covered services. In an emergency transportation is to the nearest appropriate emergency facility.

Vocational Services - Services to prepare the person for or maintain competitive employment. Activities include but are not limited to vocational screening, evaluation and training, and sheltered or supported employment.